AN INTERESTING CASE OF A 12 CM BARTHOLIN ABSCESS WITH 300 ML BLOOD DRAINED: A CASE REPORT

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BACKGROUND

The Bartholin glands are paired mucin-secreting vestibular glands located at the posterolateral aspect of the vaginal introitus that provides vulvovaginal lubrication. Obstruction of the distal duct results in retention cyst formation, which may subsequently become secondarily infected, leading to abscess development. Bartholin gland abscesses are common vulval infections in reproductive-aged women when a cyst becomes infected. They are typically 2-4 cm in size

DISCUSSION

The cyst size and volume of haemorrhagic drainage is atypical and raised important intraoperative diagnostic and management considerations. Bartholin abscesses are generally confined to the superficial perineal space; however, progressive duct obstruction with ongoing infection may permit expansion into adjacent vulval tissues. The presence of blood-stained fluid in this case may reflect pressure-related vascular congestion, capillary disruption within the inflamed gland, or superimposed haematoma formation. Importantly, no active arterial bleeding was identified intraoperatively, and the patient remained haemodynamically stable, supporting a reactive rather than primary vascular aetiology.

Common causative organisms include Escherichia coli, anaerobes, polymicrobial vaginal flora and sexually transmitted infections including Neiserria Gonorrhoeae and Chlamydia trachomatis. Routine management of a Bartholin abscess include antibiotics; word catheter; and incision, drainage and marsupialisation of the cyst. The aim is to promote epithelialisation and reducing recurrence risk. Biopsy is recommended to exclude a Bartholin gland carcinoma.

CASE

49 year old female, Para 2, presented with a 2 month increase in pain and size of left vulva swelling limiting walking and sitting . She also had dyspareunia, associated fever (37.9) and myalgia. She had an ultrasound confirmed 6 cm left sided Bartholin cyst for 2-years which was asymptomatic. The rapid increase in the size of the cyst occured after an abnormally heavy period 2-months prior to hospital presentation, with minimal improvement with simple analgesia. She was perimenopausal with her no periods for 9 months prior to her last period, with a history of irregular periods. She had She had diet-controlled Hypertension, no known allergies or regular medications. Last cervical screen was normal and up to date.

Examination showed a tender 10 cm fluctuant left labial swelling.

She was commenced on Intravenous Flucloxacillin 2g four times a day for 24 hours prior to incision, drainage and marsupialisation.

RESULT

Haemoglobin 114, White cell count 12.9, Neutrophils 9.83 CRP 43.5

A pelvic ultrasound showed a 95 x 80 x 76mm collection with internal debris within the superficial layer of the left labia, with no internal vascularity and partially fluctuant.

She had an incision, drainage and Marsupialisation. Intra-operative findings: 12-cm blood filled cysts with areas of necrosis within - 300 mls drained.

Biopsy of tissue confirmed benign ciliated cyst. Intra-operative swab and cultured fluid revealed mixed vaginal flora.